Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection
Mortality Review
Aleda E. Lutz VA Medical Center
Saginaw, Michigan

Report No. 10-00687-223 **August 16, 2010**

VA Office of Inspector General
Washington, DC 20420

Executive Summary

The purpose of this review was to determine the validity of allegations regarding deaths at the Aleda E. Lutz VA Medical Center (the medical center), Saginaw, Michigan. The complainant specifically alleged medical center clinical staff failed to appropriately diagnose patients and did not report an emergency department (ED) death to the Medical Examiner (ME). The complainant was unable to provide specific cases regarding alleged misdiagnosis but did provide names of four patients who allegedly should have had autopsies. The complainant further alleged that the number of autopsies had significantly decreased and that the medical center was under reporting deaths to the ME. We were unable to find documentation that correlated with personally identifiable information the complainant reported for the alleged fourth patient, so our review was limited to three patients.

We did not substantiate that the identified patients did not have appropriate requests for autopsy or that the deaths had not been appropriately reported to the ME. The medical center does not perform autopsies onsite and, if indicated, physicians consult the ME to schedule arrangements to transport the body to a local medical facility where autopsies are performed. The first patient's family declined an autopsy and the case was discussed with the ME who decided an autopsy was not necessary. The second patient had an autopsy and the third died in a local hospital where request for autopsy would have been handled. The medical center had documented quarterly death rate analyses and monitored autopsy rates and requests for autopsy. In fiscal year 2009, there was 100 percent compliance with requests for autopsy following deaths.

During our review of the care for the first patient, we identified aspects of care warranting improvement. The ED physician should have adhered to nationally accepted clinical practice guidelines for the management of acute coronary syndrome (ACS). The physician discharged the patient who remained "groggy" after the administration of pain medication and was unable to drive himself home. Although nurses did not allow the patient to leave, he was not observed and appropriately monitored. The patient was found nonresponsive without pulse and respirations and staff initiated cardiopulmonary resuscitation. Staff did not follow national guidelines for resuscitation management. Local policies for intubation and airway management defined conflicting responsibilities and staff competency had not been assessed.

The Veterans Integrated Service Network and System Directors concurred with our recommendations to ensure that staff follow ACS guidelines, appropriately monitor patients at all times, follow national resuscitation guidelines and review all resuscitation efforts for compliance with those guidelines, and comply with Veterans Health Administration policy for Out-of-Operating Room Airway Management. The actions taken are acceptable and we consider the recommendations closed.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans in Partnership Network (10N11)

SUBJECT: Healthcare Inspection – Mortality Review, Aleda E. Lutz VA Medical Center, Saginaw, Michigan

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations made by a complainant to the OIG Hotline Section regarding deaths at the Aleda E. Lutz VA Medical Center (the medical center), Saginaw, Michigan.

Background

The medical center provides primary and secondary medical, ambulatory surgical, and outpatient psychiatric services to more than 26,000 veterans living in the central and northern 35 counties in Michigan's Lower Peninsula. The medical center is part of Veterans Integrated Service Network (VISN) 11.

According to local policy, the medical center will accommodate the needs of veterans with urgent or emergent health care needs within the scope of a primary health care delivery model. The medical center has an emergency department (ED) with life support equipment. However, patients requiring tertiary care or management of major trauma are transferred to an appropriate VA or private sector facility. Local ambulances do not transport emergency patients to the ED. Medical center registered nurses (RNs) and physicians are available to triage patients on a 24-hour basis. During non-administrative hours, the nursing supervisor is responsible for patient triage and the Medical Officer of the Day (MOD) provides physician coverage.

The OIG Hotline Division received a complaint that medical center clinical staff failed to appropriately diagnose patients and did not report an ED death to the Medical Examiner (ME). We conducted a telephone interview with the complainant to clarify the allegations and request supporting documents. The complainant was unable to provide specific cases regarding alleged misdiagnosis but did provide names of four patients who

allegedly should have had autopsies. The complainant further alleged that the number of medical center autopsies had significantly decreased and that the medical center was under reporting deaths to the ME.

The complainant specifically alleged that during random medical record reviews, he discovered there were no autopsy requests for the following cases:

- Patient 1 presented to the ED with left arm pain. Following evaluation and treatment, a physician wrote discharge orders. However, the patient remained in the ED for observation after RNs determined that it was not safe for him to drive himself home because of the pain medication he had received. Although the patient fell twice, nursing staff did not contact the MOD. Staff found the patient unresponsive the next morning and the patient died that day.
- Patient 2 presented to the ED with uncontrolled diabetes. He fell and hit his head during a routine x-ray. A computed tomography (CT) scan following the fall showed intracranial bleeding. Despite treatment, the patient collapsed and died the next day.
- Patient 3 fell and fractured his arm while waiting for transfer to the Ann Arbor VA Medical Center for a urology appointment. The complainant reported that a police officer said the patient was handled roughly. The patient died after being transferred to a local hospital and placed on a ventilator.
- Patient 4 fell while in the community living center and required sutures for a head injury following a fall. This patient was a fall risk and fell again.

Scope and Methodology

We conducted a telephone interview with the complainant on January 14, 2010, to clarify the allegations. We also spoke with the VISN and Medical Center Directors, the former Acting Chief of Staff (COS), and the newly appointed COS via telephone. Medical center management informed us that an Administrative Investigative Board (AIB) reviewed circumstances surrounding the first patient's death.

We reviewed results of the AIB, medical record documentation, medical center policies and procedures, quality management documents, committee minutes, and employee education and competency records. We were unable to find documentation that correlated with personally identifiable information the complainant reported for the alleged fourth patient, so our review was limited to three patients.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Clinical Case Reviews

Patient 1

The patient presented to the medical center ED at 7:50 p.m., with 2 days of neck pain radiating to the left arm. The patient had a history of diabetes mellitus, coronary artery disease, congestive heart failure (CHF), and chronic obstructive pulmonary disease. The patient reported that throughout the day he had been taking aspirin for pain.

The ED staff placed the patient on supplemental oxygen, inserted an intravenous (IV) catheter, collected blood for glucose testing, and obtained a 12-lead EKG. The glucose was normal and the EKG showed controlled atrial fibrillation. The MOD noted decreased range of motion in the left shoulder and decreased sensation in the upper left arm. The patient stated he had been moving furniture the day before but denied any trauma. The MOD documented the assessment that the patient did not have acute coronary syndrome (ACS). Left arm and shoulder x-rays were negative for fractures and a CT scan showed severe cervical spondylosis.[1]

The patient received subcutaneous injections of hydromorphone for pain relief at 8:14 p.m. and 8:40 p.m. Approximately 2 hours after the second hydromorphone injection, the patient denied pain. The MOD completed discharge instructions at 10:50 p.m. and documented that, although the arm pain was relieved, numbness persisted. The patient was instructed to follow up with his primary care provider in 1 week and have further diagnostic imaging studies for his arm and neck. An RN documented that the patient was "groggy" and was aware of his inability to drive, so RNs continued to observe the patient. At 11:59 p.m., the RN noted that report was given and care assigned to the RN supervisor taking over the next shift.

Although there is no further documentation in the medical record until after the patient's death, sworn testimony submitted to the AIB provided further information. A student nurse technician (SNT), who was assigned by the RN supervisor to check on the patient, found him on a bathroom floor at approximately 1:00 a.m. The SNT told the AIB that the patient was drooling, was cold and sweaty, and was difficult to arouse when she found him. The MOD was not notified of the incident and no fall report or patient assessment was documented.

The MOD documented that at approximately 4:00 a.m. staff initiated a code blue, began cardiopulmonary resuscitation (CPR), and inserted a combitube.[2] Staff could not obtain

[1] A chronic degenerative condition involving the spine and adjacent structures in the neck.
[2] An airway device often utilized in the pre-hospital, emergency setting to facilitate the intubation of a patient in respiratory distress.

IV access, and no medications were administered. The patient was in asystole[3] with no pulse and after approximately 25 minutes staff discontinued resuscitation measures. The MOD pronounced the patient dead at 4:38 a.m., noting "sudden cardiac death secondary to cardiac arrhythmia most likely cause of death."

According to medical records, the MOD discussed the death with the medical examiner and they decided that an autopsy was not necessary. The MOD documented that the family declined an autopsy for "personal reasons."

Patient 2

During a compensation and pension (C&P) evaluation at the medical center, the patient reported he had stopped taking his insulin several weeks before because his blood glucose levels had been low. The patient also mentioned he had experienced weakness and had recently fallen in his home. The patient had a history of uncontrolled diabetes mellitus, coronary artery disease with a pacemaker, atrial fibrillation, and CHF. The C&P nurse practitioner (NP) ordered laboratory tests to be drawn immediately and the blood glucose level was reported to be 846 mg/dL.[4] Because of the extremely high blood glucose level, the NP stopped the C&P evaluation and the patient was transported by wheelchair to the ED.

The ED physician evaluated the patient and noted the patient's choice of code status as do not resuscitate (DNR).[5] The patient reported to an ED RN that he had been lightheaded, had been falling over the last several months, and had fallen in the shower stall the day before. The RN noted the patient had a small bruise on his back. The ED physician treated the patient with insulin, documented the patient's prognosis as "poor," and transferred the patient to the intensive care unit (ICU) for ongoing treatment. The patient was treated with vitamin K to reverse anticoagulation from medication he had been taking for atrial fibrillation.[6] ICU RNs assessed the patient as a high risk for falls and the patient was placed on fall precautions.

On hospital day 2 (HD2), ICU staff transported the patient to Radiology for a routine chest x-ray. The patient fell while in Radiology, hitting the left side of his forehead. Radiology technicians reported the fall to a physician and the nursing supervisor, and a CT scan of the head was completed within 30 minutes after the fall. The physician documented that the patient was doing well clinically, but the head CT showed a small amount of bleeding. The physician consulted a neurosurgeon at the Ann Arbor VA Medical Center (AAVAMC) who recommended discontinuing the prophylactic

[3] Cardiac standstill with no heart function or output.
[4] Normal blood glucose range is 50-200 mg/dL.
[5] In case of cardiac or respiratory arrest, physicians would not initiate life saving interventions.
[6] Rapid irregular twitching of the upper chambers of the heart.

anticoagulants[7] the patient had been on, giving fresh frozen plasma (FFP),[8] and repeating a head CT the next day. The physician ordered RNs to conduct neurological assessments every 4 hours and provided instructions to transfer the patient to a local hospital if abnormalities developed. The patient remained alert and oriented.

On HD3, the physician reported that the patient had done well the previous night. A repeat head CT showed increased bleeding and the AAVAMC neurosurgeon recommended transfer to a local hospital. The physician who obtained the patient's consent for transfer noted that the patient said he was "not feeling well." An RN asked the patient if he would like assistance contacting his brother (next of kin), but the patient stated he would do that himself. While the physician and RN were at the bedside, the patient's blood pressure and pulse dropped and he became unresponsive and without a pulse or respirations. Because of the patient's DNR status, there was no attempt to resuscitate him. The physician's death note indicated that the death was not an ME case.

Staff were able to contact the patient's brother approximately 2 hours after the death. The brother requested an autopsy to determine the cause of death. The autopsy report stated that the patient had sustained "minor head injury…not contributing to his death. The manner of death is natural."

Patient 3

The patient had recently been hospitalized with a urinary tract infection and sepsis. He had an uncharacterized renal mass and a history of hypertension, coronary artery disease, chronic obstructive pulmonary diseases, and benign prostatic hypertrophy. In December 2009, staff from the private nursing home where the patient resided brought the patient to the medical center for transport to the AAVAMC for a urology appointment. While they were transferring the patient from one wheelchair to another, the patient's "knees started to give out." The nursing home staff supported him under his arms, lowered him to the floor, and reported they felt his right arm "crunch."

ED staff assumed care of the patient and ordered laboratory tests and x-rays of the patient's left knee and right arm. The patient was given pain medication for a pain score of 7 out of 10 (10 indicates severe pain). X-rays showed no fracture of the knee but there was a fracture of the right upper arm. The patient was transferred to a local hospital for treatment.

At the local hospital, a physician treated the fracture conservatively by applying a brace to the arm. In addition, a urologist evaluated the patient's renal mass. On HD3, the patient remained clinically stable and staff expected the patient to be discharged. Later

[7] Medications administered to prevent blood clots.
[8] Portion of blood containing no cells, used to correct coagulation factor deficiencies.

that day, an RN reported that the patient arrested and was transferred to ICU, where physicians placed him on a ventilator. He died that same day.

Issue 1: Request for Autopsy and ME Reporting

We did not substantiate that the identified patients did not have appropriate requests for autopsy or that the deaths had not been appropriately reported to the ME.

According to medical center policy, a licensed independent practitioner is responsible for requesting permission to perform an autopsy from the next of kin or designee. Cases that require autopsy are defined in the policy. The medical center does not conduct autopsies onsite. The ME is consulted to schedule arrangements to transport the body to a local medical facility where autopsies are performed. The medical center uses a template death note that includes a mandated field for request for autopsy and a field asking if the death was a ME case. Physicians completed these fields for each of the patients reviewed.

Patient 1's family declined an autopsy. Because the death occurred in the ED, the case was discussed with the ME, who decided that an autopsy was not necessary. Patient 2's brother requested an autopsy and it was completed. Patient 3 died in a local hospital, so any request for autopsy would have been handled by that facility.

The complainant further alleged that the number of medical center autopsies had significantly decreased. Excluding the Community Living Center, there were 12 deaths at the medical center in fiscal year (FY) 2009. One of those deaths had an autopsy completed. The QM Coordinator performs a quarterly death rate analysis and, as part of that analysis, monitors autopsy rates and requests for autopsy. In FY 2009, there was 100 percent compliance with requests for autopsy following deaths.

Deaths are also reviewed and discussed as part of the peer review process. We found no indication that deaths were not reviewed or appropriately reported to the ME.

Issue 2: Identified Opportunities to Improve Care

During our review of the care for Patient 1, we identified aspects of care warranting improvement.

ACS Standard of Care

ED staff did not treat this patient with known coronary artery disease according to ACS standards of care when he presented with left arm pain. Staff implemented some ACS interventions (supplemental oxygen, IV, and EKG) and the physician documented that the patient did not have ACS symptoms. However, the patient's cardiac history and presenting symptom of neck and arm pain should have prompted cardiac biomarker

testing.[9] Biomarkers help detect the presence of ACS and evaluate severity so that appropriate therapy can be initiated; their use in ACS patients is a VHA Performance Measure.

Patient Monitoring

The ED physician discharged Patient 1 because he was no longer having arm pain. However, an RN confirmed that the patient could not drive himself home because he was still "groggy." Following the shift change, the patient was not appropriately observed. The pain medication that was given can cause dizziness and increase the risk for falls. The medical center does not have 24-hour coverage in the ED and nursing supervisors have other responsibilities to perform that would not allow them to continually observe patients. The patient should have been admitted for observation or not discharged from the ED.

The medical center AIB addressed specific issues with the nursing care of the patient and recommended administrative actions.

Resuscitation Management

Staff did not follow Advanced Cardiac Life Support (ACLS) guidelines as required by VHA policy[10] for resuscitation management. Staff did not insert an oral endotracheal (ET) tube during the code. ET intubation is the airway management procedure of choice for cardiac or respiratory arrest. Proper insertion and confirmed placement of an ET tube ensure adequate oxygenation of vital organs. Critical emergency medications were not administered because staff could not obtain IV access. These medications could have been administered through an ET tube but not through the combitube that was inserted. Although a medical center peer review was conducted, it did not include the care provided after staff found the patient unresponsive. There is a process in place for resuscitation review through the ICU Committee, but a thorough review did not occur.

Staff Competency

Documentation of resuscitation efforts was minimal; the medical center form was not completed as required by local policy. As a result, it was difficult to determine the course of events and staff responsible for actions. According to the local policy for out-of-operating room airway management, the nursing supervisor is responsible for intubation during non-administrative hours. VHA requires that staff who perform urgent and emergent airway management outside of facility operating rooms maintain appropriate

[9] Substances released into the blood when the heart is damaged. Because they are more specific for heart injury, troponins are the preferred cardiac biomarker and are considered the definitive test for determining ACS.
[10] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

competency.[11] The nursing supervisor's annual competency assessment did not include airway management or other assigned clinical triage functions specified in the scope of practice.

Conclusions

We found no quality of care concerns for Patients 2 and 3. We could not substantiate or refute allegations that Patient 3 was "handled roughly" during a fall. Although surveillance cameras captured the fall on video, a video record of the event was not available because medical center police do not retain the videos more than 45 days. The police record documented that the fall occurred; however, there was no evidence to suggest that the patient was "handled roughly."

Patients with diabetes are at increased risk of developing cardiovascular disease and can have painless heart ischemia.[12] Consequently, diabetic ACS patients might present to the ED with vague or absent signs and symptoms. In the care of Patient 1 the physician should have adhered to nationally accepted clinical practice guidelines for the management of ACS.

Patients who are unable to leave the medical center on their own accord must either be accompanied or remain under care until they are able to be discharged. According to local policy, the medical center does have observation beds. Patient 1 was not monitored appropriately. Although it was not possible to determine when he became unresponsive, emergency response measures were probably delayed. When the patient did arrest, ED staff did not adhere to ACLS guidelines for resuscitation management.

Local policies defined conflicting responsibilities for intubation and airway management. One policy stated that privileged medical staff perform emergency intubation and airway management during administrative hours, with nursing supervisors responsible during non-administrative hours. However, another local policy regarding emergency response states that respiratory therapists provide airway management during both administrative and non-administrative hours. This conflict could lead to confusion in emergency situations. Although the local policy for emergency airway management was in compliance with VHA requirements, competency had not been assessed as defined in the policy.

[11] VHA Directive 2005-031, *Out-of-Operating Room Airway Management,* August 8, 2005.
[12] Insufficient blood flow.

Recommendations

Recommendation 1. We recommended the VISN Director ensures that the Medical Center Director requires staff to follow ACS guidelines and VHA Performance Measures.

Recommendation 2. We recommended the VISN Director ensures that the Medical Center Director requires staff to appropriately monitor patients at all times.

Recommendation 3. We recommended the VISN Director ensures that the Medical Center Director requires staff to follow ACLS resuscitation guidelines and review all resuscitation efforts for compliance with those guidelines.

Recommendation 4. We recommended the VISN Director ensures the medical center is in compliance with VHA Directive 2005-031, *Out-of-Operating Room Airway Management*.

Comments

The VISN and System Directors concurred with the inspection results (see Appendixes A and B, pages 11–15, for the full text of their comments and completed actions). The actions taken are acceptable and we consider the recommendations closed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 23, 2010

From: Director, Veterans in Partnership Network (10N11)

Subject: **Healthcare Inspection – Mortality Review, Aleda E. Lutz VA Medical Center, Saginaw, Michigan**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Per your request, attached is the response from Saginaw VAMC. Please contact Jim Rice, QMO at 734-222-4314 if you have any questions.

Michael S. Finegan

Attachment

Department of Veterans Affairs **Memorandum**

Date: July 19, 2010

From: Medical Center Director (655/00)

Subject: **Healthcare Inspection – Mortality Review, Aleda E. Lutz VA Medical Center, Saginaw, Michigan**

To: Director, Veterans in Partnership Network (10N11)

1. On behalf of the Aleda E. Lutz VAMC, I would like to take this opportunity to express my sincere appreciation to the Office of the Inspector General (OIG), Healthcare Inspection Mortality review team for their professionalism, consultative approach, and excellent feedback provided to staff during the review process from January 21, 2010 through July 8, 2010.

2. The recommendations were reviewed and I concur with the findings. Our comments and implementation plan are delineated attached. Corrective action plans have been developed or executed for continuous monitoring. Aleda E. Lutz VAMC welcomes the external perspective provided, which we will utilize to further strengthen the quality of care we provide to our Veterans.

3. Should you have questions or require additional information, please do not hesitate to contact Margaret Russell, Chief of Quality Management, at (989) 497-2500, extension 13032.

   (signed original on file)

   DENISE M. DEITZEN

   Attachment

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

Recommendation 1. We recommended the VISN Director ensures that the Medical Center Director requires staff to follow ACS guidelines and VHA Performance Measures.

Concur

On November 5, 2009, after an in depth review including staff, stakeholders, and VISN input, the Saginaw Veterans Affairs Medical Center requested redesignation of the Emergency Department to an Urgent Care Department through the Under Secretary for Health. Approval was received February 25, 2010 and after extensive planning and communications, the Emergency Department redesignation to an Urgent Care Department occurred on June 17, 2010.

Every patient who presents to the Urgent Care is evaluated for ACS symptoms (chest pain, shortness of breath, diaphoresis, nausea and/or epigastric pain, unexplained indigestion/belching, or pain radiating in neck, jaw, shoulders, back or arms) during triage. This is a mandatory field in the nursing triage note and signage in the waiting room alerts our Veterans to report any such symptoms immediately.

The medical center utilizes standardized Computerized Patient Record System (CPRS) order sets for ACS patients and all staff has received training on these order sets. Peer reviews are conducted on fallouts i.e., staff not correctly initiating ACS protocols based on the criteria built into the process.

Post Code Blue Reviews and team huddles are conducted on 100% of Code Blues. Team huddles and post Code Blue Reviews are tracked, trended and aggregated at the Acute Care Telemetry (ACT) Committee. Chief of Staff also reviews the post Code Blue Reviews and provides feedback to team members.

Summary of Codes:
FY 2009 3rd Quarter - 1 Code Blue, No ACS fallouts and no issues identified
FY 2009 4th Quarter - 1 Code Blue, No ACS fallouts and no issues identified
FY 2010 1st Quarter - 2 Code Blues, No ACS fallouts and no issues identified
FY 2010 2nd Quarter - 1 Code Blue, No ACS fallouts and no issues identified

An assessment of the emergency crash carts was undertaken. Processes for the standardization of equipment and supplies, pharmaceutical agents, check lists, and post-

code cleaning and re-stocking have been developed. Monitoring of all processes occurs monthly with reporting to the ACT Committee. FY 2009 review indicated a 99.8% compliance rate for crash cart monitoring and FY 2010 (year to date) shows a 99.5% compliance with above requirements. **Recommend closure.**

Recommendation 2. We recommended the VISN Director ensures that the Medical Center Director requires staff to appropriately monitor patients at all times.

Concur

Medical Center Memorandum (MCM) 11-05, Code Blue Emergency Response, was updated to ensure compliance with all VHA Directives. This was completed March 2010. MCM 11-01, Ambulatory Care Emergency Department Services, outlines the care provided in the emergency department including utilization of Emergency Severity Index (ESI), Version 4. This MCM has been reviewed with all Emergency Department staff; staff is monitored for compliance through supervisory chart reviews.

Nursing Service Memorandums (NSM) 2-02, Nursing Service Safety Program & Emergency Plan Procedures, and NSM 5-03, Report of Patient's Condition and Nursing Unit Activities, detail the nurse managers' and nursing supervisors' responsibilities with regard to maintaining and monitoring staff's compliance with safety/emergency practices (including monitoring of patients). The specific nursing supervisor involved in the emergency department incident was not following medical center policy. An Administrative Investigative Board was conducted and appropriate administrative action was completed on January 23, 2009. **Recommend Closure**

Recommendation 3. We recommended the VISN Director ensures that the Medical Center Director requires staff to follow ACLS resuscitation guidelines and review all resuscitation efforts for compliance with those guidelines.

Concur

ACLS Certification must be completed within the first six months of new assignment and be maintained in a current status, (unless pre-requisite courses are needed) for all positions in the Medical Center that require this training. In compliance with MCM 11-05, ACLS Certification is required for all Medical Officers of the Day, Inpatient Licensed Independent Providers (LIP), and Primary Care LIPs to include Registered Nurses (RN), Licensed Practical Nurses, all Nursing Supervisors, Surgeons, and Certified Registered Nurse Anesthetist (CRNA), who are assigned (or may be assigned) to the Urgent Care/Telemetry/Stress Test Settings/Same Day Surgery/Operating Room, and all inpatient settings. Training is currently at 100% completion.

Medical Center Memorandum 11-05, Code Blue Emergency Response, was updated to ensure compliance with VHA Directives. This was completed March 2010. All Code Blue cases (100%) will be reviewed within one business day by a representative of the ACT Committee with areas of concern immediately reported to the Chief of Staff. All Code Blue cases will continue to be assessed at the monthly ACT Committee with a report to Medical Staff Executive Committee. The Chief of Staff also independently reviews all post-Code Blue documentation to ensure compliance with MCM 11-05, VHA Directives, and ACLS Guidelines. **Recommend closure.**

Recommendation 4. We recommended the VISN Director ensures the medical center is in compliance with VHA Directive 2005-031, *Out-of-Operating Room Airway Management*.

Concur

Out-of-OR Airway management has been expanded to ensure that appropriate front-line, dependent staff (RN and Respiratory Therapy (RT) staff) who may reasonably be expected to encounter a cardiopulmonary arrest obtain the competency to perform out-of-OR intubations. The CRNA at Saginaw VAMC will continue to serve as the point-of-contact to ensure that appropriate Out-of-OR airway management education is obtained consistent with VHA Directive 2005-031, sections 4b(1)(b) and 4b(2), as well as Attachment A, sections 3a, 3b, and 3c. Competencies have been developed and updated by Human Resources Management Service to reflect a more thorough evaluation of the dependent providers prior to competency attainment. Supervisors complete an annual competency review of all licensed providers to assure yearly competencies are attained. Human Resources Management Service has developed a tracking tool to monitor annual Out-of-Operating Room Annual Competencies for RNs and RTs. Nursing Supervisors' competencies are 100% current in the past year. RT staff members are trained on bag mask and king tube only. RT competencies for bag mask and king tube are also 100% current for the past year.

LIPs are monitored for competency through the Professional Standards Board (PSB) with education, assessment, and tracking performed by the CRNA. A specific line-item privilege has been added to all privilege request lists and scopes of practice ensuring that the PSB reviews current competency when awarding privileges. The CRNA also independently tracks all certified LIPs to ensure performance of the annual re-assessment and training for Out-of-OR Airway management. **Recommend closure.**

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Dorothy Duncan, Associate Director Kansas City Office of Healthcare Inspections (816) 997-6966
Acknowledgments	Reba B. Ransom, Team Leader Jerome Herbers, Physician Consultant

Appendix D

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